Developmental Vision Care, P.C. Kenneth R. Westcott, O.D.

601 Innovation Dr. Suite B, Chesapeake, VA 23320 Developmental Optometrist

Phone (757) 410-3005 Fax (757) 410-3335

www.d-visioncare.com

Date ______________

General History

GENERAL INFORMATION

Patient's name______________________________

Parent, if child______________________________

Home phone______________________________

Cell phone______________________________

E-mail______________________________

Home address______________________________

City__________________State______Zip________

Age_______Birthdate______________________

Sex: M F Marital Status: S M D W

Occupation/ Grade______________________________

Employer/School______________________________

Work phone______________________________

Spouse's name______________________________

Emergency Contact______________________________

Contact phone number______________________________

Medical doctor______________________________

Referred by______________________________

MEDICAL HEALTH HISTORY

Current medications______________________________

____

For what condition?______________________________

____

List any major illness	Age	Mild / Severe
______________	___	________
______________	___	________

Any history of the following?	**You**	**Family (list whom)**
Diabetes	❒	❒ ________
High Blood Pressure	❒	❒ ________
Heart / Lung Disease	❒	❒ ________
Thyroid Disease	❒	❒ ________
Cancer	❒	❒ ________
Inflammatory/Infectious Disease	❒	❒ ________
Stroke / Traumatic brain injury	❒	❒ ________
Learning Problems	❒	❒ ________
Lazy eye / Amblyopia	❒	❒ ________
Eye turn / Strabismus	❒	❒ ________
Eye Injury / Eye Surgery	❒	❒ ________
Visual Field Loss	❒	❒ ________
Cataracts	❒	❒ ________
Glaucoma / Glaucoma suspect	❒	❒ ________
Macular / Retinal Disease	❒	❒ ________

VISUAL HEALTH HISTORY

In what ways are you having visual difficulty?____

____

____

Last vision examination ______________________

By doctor______________________________

Results______________________________

Do you wear glasses? ❒ Yes ❒ No

- ❒ Constantly ❒ Occasionally
- ❒ Bifocal ❒ No-line
- ❒ Reading only ❒ Far only

Do you wear contact lenses? ❒ Yes ❒ No

- ❒ Full time wear ❒ Occasional wear

For how many years? ______________________

Type:
- ❒ Soft Lens ❒ Gas Permeable
- ❒ Daily wear ❒ Extended wear
- ❒ Disposable ❒ Soft toric
- ❒ Bifocal ❒ Monovision

Current contacts:______________________

Replacement schedule:__________________

Disinfection solution:__________________

Do you ever have any of the following, and if so, when?

	No	Yes	When?
Blur at distance	❒	❒	______________
Blur at near	❒	❒	______________
Eyes hurt or tired	❒	❒	______________
Headaches	❒	❒	______________
Double vision	❒	❒	______________
Flashes/floaters	❒	❒	______________

Have you ever noticed any of the following?

	Never	**Always**	**Occasionally**
Holding reading close or far	❒	❒	❒
Frequent styes / pinkeye	❒	❒	❒
Excessive eye rubbing	❒	❒	❒
Bothered by light	❒	❒	❒
Closing/covering one eye	❒	❒	❒
Words moving on page	❒	❒	❒
Loses place when reading	❒	❒	❒
Uses finger to keep place	❒	❒	❒
Reads slowly	❒	❒	❒
Poor comprehension	❒	❒	❒
Slow to complete schoolwork	❒	❒	❒
Bumping into objects	❒	❒	❒
Poor general coordination	❒	❒	❒

Please complete the other side.

Review of Systems

Please circle all that currently apply to the patient only. If none apply (n/a), please check the box. **n/a**

	n/a
Constitutional: Recent weight gain or loss, Fever today, Often fatigued, Fainting	❒
Ears, Nose, Throat: Earaches or drainage, Sinus problems, Nose bleeds, Bleeding gums, Hearing loss, Sore mouth or throat, Ringing in ears	❒
Neurological: Numbness, Tingling, Paralysis, Severe headache, Dizziness/Vertigo, Seizures, Tremors, Past head injuries	❒
Hematological / Lymphatic: Anemia, Bruised easily, Slow wound healing, Phlebitis, Slow healing, Swollen glands, Past blood transfusion	❒
Musculoskeletal: Joint pain or stiffness, Muscle pain or cramps, Back Pains, Cold extremities, Difficulty walking, Frequent "growing pains"	❒
Gastrointestinal: Loss of appetite, Abdominal pain, Stool changes, Chronic diarrhea, Nausea/Vomiting, Constipation, Blood in stool, Reflux	❒
Psychiatric: Memory loss, Confusion, Depression, Nervousness, Insomnia, Unable to concentrate, ADHD	❒
Cardiovascular: Heart trouble, Chest pain, Palpitations, Murmur, Valve defects, Swelling of feet/ankles or hands, prior heart attack	❒
Respiratory: Chronic Cough, Shortness of breath, Wheezing, Coughing up blood	❒
Allergic / Immunologic: Hay fever, Asthma, Environmental allergy, Food or gluten allergy	❒
Endocrine: Heat/cold Intolerance, Hot flashes, Excessive appetite, Excessive thirst, Frequent urination	❒
Skin / Breast: Rashes, Lesions, Birthmarks that have changed color or size, Breast lump, Excessive dryness,	❒
Genitourinary: Blood in urine, Discharge, Pain with urination, Frequent bedwetting	❒

Current state of health: ❒ Good ❒ Fair ❒ Poor Other health problems____

Do you use tobacco? ❒ No ❒ Yes: ___packs/day Alcohol? ❒ No ❒Yes Narcotics? ❒ No ❒Yes

(Some insurers require this question)

Are you allergic to any medications? ❒ No ❒Yes, list: ____

Is there any other information you feel would be helpful / important in the treatment of you or your child?

____

____

____

____

Privacy Information

We want our patients to know that we have a privacy policy in place for your protection. You have the right to review our Notice of Privacy Policy. It is available at our reception desk for the asking.

I acknowledge that I have read (or been given the opportunity to read) the Notice. Please initial here ___________

Release of Information and Insurance Filing

I authorize the release of any medical information to communicate with another professional who has referred me or for the referral to another doctor, school or clinic.

_________________________________ _________________________________ _________

Signature For child: Relationship to patient Date

I hereby give my permission to Developmental Vision Care, P.C. to treat _________________________.

(Child's name)

_________________________________ __________

Parent's or Guardian's Signature Date

In order for us to keep costs down, payment is expected in full at the time of service.
We will provide a detailed receipt that may be submitted to your insurance carrier.

Would you like to receive notification of our free vision workshops? ❒ yes ❒ no

I am interested in the following topics:

❒ How Vision Affects Learning ❒ Classroom Accommodations ❒ ADHD: Unlocking the Mystery ❒ Kindergarten Readiness
❒ Reaching the Reluctant Reader ❒ Handwriting Help ❒ Remediation of letter Reversals ❒ Becoming a Super Speller

HELP US SPREAD THE WORD…***Like*** **us on Facebook** www.facebook.com/developmentalvisioncare